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Review Article

Barriers to access healthcare among the elderly population in rural regions of India

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ABSTRACT

Aging care is critical. Hence, the best-known newly developed technologies must be provided to the older population. This paper explains the need for mapping of strategies that must address preventive and promotional care and sickness management, empowering geriatric services, and guaranteeing optimal rehabilitation for the elderly population of India. Databases considered to carry out the literature review was Scopus, PubMed and Web of Science. Scientific articles published in English were only considered. Apart from scientific articles, government report, and newspaper articles, were also reviewed. Data was managed in Mendeley software. Articles based on elderly residing in urban populations and other age groups were excluded from the study. There are multiple barriers between the elderly beneficiaries and the healthcare services which stop the utilization of healthcare services. It can be demographic, aging, geographic, economic, accessibility, psychological, housing, transportation, medical, and social. Financial security is the top reason for not availing of healthcare services, followed by the perception that the ailment is not serious enough. The second reason was the unavailability of accessible healthcare facilities. Therefore, elderly people residing in rural regions, are more prone to varying diseases and are vulnerable to health inequity among other age groups in India. Considering the projected demography, it will only get worse until there is an intervention and feasible infrastructure, healthcare facilities, and services are provided in collaboration with local stakeholders and program monitors.

Keywords: Accessibility, Elderly, Geriatric, Psychological, Social

INTRODUCTION

A mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's thinking, emotion regulation, or behaviour that reflects a dysfunction of the psychological, biological, or developmental processes underlying mental functioning and impairment in social, occupational, or other day-to-day activities.[1] Psychiatrists and mental health professionals use a wide variety of questionnaires, interviews, checklists, outcome assessments, and other tools to assess the plan of treatment, aid in the diagnosis, identify comorbidities and assess the level of functioning. It is challenging in the field of psychiatry, to classify the various mental disorder to assess the severity and quality of life, over the change of time. Rating is a term used to express an opinion or judgment regarding the performance of a person, object, situation, or character.

The country's healthcare framework positions are mostly dependent on out-of-pocket expenditures subject to limited health insurance coverage and private healthcare sectors in the world. Progress has happened in the past 5 years with new responsibilities by focal and state legislatures to address a portion of these imbalances and lacunae in medical care affordability. The healthcare services framework in India should be reconfigured in the event that these responsibilities are to give ideal advantages to individuals. Several kinds of research state that the most vulnerable are the geriatric age group, of low-income countries. In addition, non-urban and non-metro populations also contribute to vulnerable groups.[1,2]

The average life span of people living in cities / urban areas is 5 years more than the life expectancy for people living in rural regions (71:66), clearly indicating the vulnerability and condition of elderly people living in rural regions. Elderly individuals face multiple challenges accessing healthcare facilities.[2]

The cause of the problem ranges from low to no financial security to assist their ill health, dearth of social engagement and security, and unavailability of opportunities and occupancy options. Their necessities again range to various degrees depending upon other financial, sickness, social, and other livelihood characteristics. It is a result of multifactorial reasons including demographic, aging, geographic, economic, accessibility, psychological, housing, transportation, medical, and social.[3]

This paper will be highlighting the barriers to accessing primary healthcare services by elderly beneficiaries in the country. Thereby aiding in developing a health policy, promoting health as a priority, and bridging the gaps between the beneficiaries and the healthcare providers. The elderly population of India must be given the most elevated need in an open approach. To support the positive financial direction that India has had during the previous 10 years, and to respect the key right, all things must be considered, to satisfactory primary healthcare services.

METHODS

Databases considered to carry out the literature review was Scopus, PubMed and Web of Science. Scientific articles published in English were only considered. Apart from scientific articles, government report, and newspaper articles, were also reviewed. Data was managed in Mendeley software. Articles based on elderly residing in urban populations and other age groups were excluded from the study.

RESULTS

Demographic factors

In India, more than 68.2% of the total (and 71% of the elderly) population resides in rural regions, so equity would demand even more attention from public healthcare facilities in rural regions than in urban areas.[5] As per the 2011 census, 104 million of India's population is elderly individuals. It has been observed through the data that the number of senior population increases in each census count. In the 2001 census, the 60+ population was only 7.08% however in the year 2011 it increased to 8.57% and it is estimated to reach 9.87% by 2021.

Ageing issues

As the geriatric population increases, there are higher chances of individual death among couples, and thereby the number of widows will also increase. Moreover, women who will lose their spouse might have the pressure to earn for living due to financial insecurity. Also, aging will be accompanied by inflated vulnerability to morbidity and mortality and we can imply that these issues of the geriatric population will require a special concern, focus, and approach. More importantly, the dependency ratio among elderly people is 14.2% (close to 15 million for over 104 million total elderly people). Studies show that over 35% of the elderly population needs medical attention and health services regularly. As 64.8% of the elderly people living in India are suffering from one or more chronic ailments.[5-7]

Geographic issues

Elderly people living in less developed regions face issues of communicable disease due to multifactorial problems and a lack of basic facilities like safe drinking water, sanitation, hygiene, and lack of cleanliness. Vector breeding sites due to paddles, farms, and deltas make the population very vulnerable to vector-borne diseases. Another fact that cannot be ignored is that the culture of open defecation in rural India is close to 67% compared to 13% in urban regions.[8] Thereby increasing the chances of quick spread of communicable diseases and easy exposure to such diseases due to low immunity in older persons.

Economic issues

Reports indicate that the mortality rate in rural regions is 50% higher than the urban areas in neonatal, and infants. When it comes to health status and health care, Indians are split into two groups - the first comprising the middle and upper classes of urban India with easy and reachable healthcare facilities which are accessible. However, the second and larger group comprises those that live below the poverty line in villages and have very few options to access health care.

The National Sample Survey (NSS, 2009-10) results clearly indicate an 88% rural-urban difference in average monthly per capita expenditure. Rural people also spend less on health care as compared to their urban counterparts. The rural population includes mostly laborers, artisans, and smallholders. They earn limited money, usually spent on basic amenities of survival namely, food, cloth, and

shelter.[9] As per WHO reports, rich people are likely to get the essential package of healthcare four times more than their counterparts.

In another report, the poor and vulnerable strata of society have to constantly choose between healthcare and their basic necessities to survive like food clothing, and shelter published by World Bank and WHO. The same report mentions that they struggle for less than 136 INR ($1.90 or £1.40) per day. Around 800 million individuals reportedly are spending over 10% of their total household budgets on 'Out of pocket' healthcare expenses.[10]

There is a difference between the percentages of senior citizens going for private medical consultation in urban areas with respect to rural areas. There is a difference between the percentages of senior citizens going for private medical consultation in urban areas with respect to rural areas. In cities, more than 50% go for privatized medical facilities whereas in rural populations only 37% of the people opt for private healthcare facilities.[11]

Social factors

A study used three parameters of social support to study the outcome in elderly people; these were the presence of respective spouses and their roles in others' lives, social support, and the frequency of social interaction. The ratio of relative mortality risk for impaired roles and available attachments impaired perceived social support and impaired frequency of social interaction estimates to be 2.04, 3.40, and 1.88 respectively. Hence it can be concluded that social factors are significantly able to predict the analysis of crude and control of 30-month mortality among the geriatric population.[12]

Psychological factors

Psychosocial health is often considered an ambiguous term but possesses multiple dimensions. One of the most important dimensions is the interaction of social and behavioral changes. In the aging process, these dimensions' act on various aspects related to the individuals. These include their well-being, quality of life, and outcomes of health due to these two aspects. Quality of life among senior citizens not only depends on their physical health but focuses more on the ability to do activities of daily living (ADL) and their social involvement. The mental health of senior citizens is underrated being an important part of overall quality of life and requires focus and attention.[13,14]

Medical issues

In most Asian countries including India, short and long-standing diseases have a higher chance of occurrence. The evidence also tells about the direct proportionality of disease with the rate of occurrence as age increases. The percentage of elderly reporting any acute morbidity in rural regions was over 25% less than their urban counterparts, with a ratio of 14:11. 64.8 of the elderly people are suffering from 64.8 chronic ailments.[11]

Housing

A study focussing on an assessment survey of senior citizens concluded with the following results with the priority order of: 7/8th financial needs (87.2%), 4/5th food security (79%), almost half for employment needs (45.3%), 3/8th of caregiver needs (38%), and almost one-fourth of housing needs (27%).

Current active fails to meet the financial schemes. Elderly women are more affected by the failure of schemes that take care of financial needs and reportedly less than 2% meet their financial needs and about 10% reach the food and nutrition needs.[7] Around 33% of the elderly people spend their own money on their healthcare expenditure, and only around 46% of the sample was receiving financial support from their children for their healthcare budget (36% men and 58% women).[11]

Transport

Transport is the major challenge faced by elderly people living in rural regions since healthcare facilities are not easy to reach for everyone, the public transport system is not very good, and they cannot travel alone every time at all odd hours, and in all the conditions. The person accompanying the elderly has to take a leave from their work and typically loses the wage for that particular day since most of those, living in villages are involved in the informal sectors of employment. Only about 50% of the elderly (39% of men and 65% of women) are accompanied by their children and/or grandchildren. 25 and are accompanied by a spouse, 5% by others (neighbors and friends), and 20% still go to see the doctor alone.[11] The long queues and chaotic management of public facilities make it worse. A report also suggests that over 10% of the total healthcare expenditure is spent on travel commutes to the facility.[11]

Access and availability of medical facilities

Projections made on the basis of the 2011 census, data show that by 2020, over 12 million geriatric populations will require ADL assistance which will reach 17.8 million in the next 10 years (2030) and 37.9 million by another 20 years (2050).[7] Although 10.6% of rural elderly get admitted to hospital as compared to 8.6% of urban, considering that 70% of them live in rural regions, out of over 90% of the elderly people that do not get hospitalized, more than 62% are from rural regions and only less than 28% from urban population.[11]

DISCUSSION

There is a huge dearth of data that can help us understand healthcare needs among the elderly population. This review was followed by explorative qualitative research by

the authors in 10 villages of eastern Uttar Pradesh in December 2018 to study the priorities and needs among the geriatric population to attain 'active aging'. It was observed after the study that financial security is the top reason for not availing healthcare services, followed by the perception that the ailment is not serious enough. The second reason was the unavailability of accessible healthcare facilities. This can be due to poor budget allocation, inadequate human resources, and untrained healthcare workers. These factors make it difficult to provide healthcare services at the doorstep.

Developed countries have established the concept of active aging, which includes a multi-directional framework helping elderly people to have a quality life in all terms. It narrates the interlinking of various factors such as engagement in social activities, food protection, and financial security, and overall security promoting optimal health and well-being while getting old.[4]

This has been evidently clear that elderly people residing in rural regions, are more prone to varying diseases and are vulnerable to health inequity among other groups in our country, and considering the projected demography, it is only going to get worse, until we intervene and provide a feasible infrastructure, healthcare facilities, services, and programs for them.

The estimated age span is the most prominent indicator for any country's healthcare system and we have seen a good growth in almost all the indicators after independence. People surviving to 60 years of life have improved significantly but there is a high disparity between the rural and urban populations. Men or women dying before the age of 70 years was 62% and 54%, respectively in rural regions, whereas the probability of their counterparts in urban settings was 40% and 30%.[15]

Accountability

The basic Yoga Convention by the Ministry of AYUSH of the Public Authority of India gave guidelines to healthcare providers treating Coronavirus. Studies have shown that yoga diminishes the occurrence of intense respiratory diseases. Accordingly, yoga might benefit the psychosocial treatment and restoration of patients with Coronavirus under isolation and segregation to decrease uneasiness and fear in this populace. Yoga sessions are conducted at a sub-center level in all the wellness centers under Ayushman Bharat Abhiyan. Thus making a pavement for the elderly to socialize and stay healthy.[16]

Under the National Programme for Health Care of the Elderly (NPHCE) there is a dedicated OPD day once a week, especially for elderly individuals at primary health care and twice a week at every community healthcare center and taluk hospital of the district.[17] Elderly care equipment such as walking sticks wheelchairs etc. is provided at the healthcare centers. District hospital maintains a separate counter for elderly OPD all days a week with 10 beds for the beneficiaries. It also comprises physiotherapy units and the supply of machinery, equipment, training, and additional human resources. Under this program, IEC activities are also taken care of such as awareness activities, education, and communication.[17]

CONCLUSION

Considering the above-mentioned challenges there is an urgent need to develop a multi-factorial framework to ensure the fulfilment of the future demands for chronic disease management and ADL services especially for the elderly population. A diverse infrastructure is required, and a multi-dimensional strategy needs to be practiced to give elderly people the assurance of basic needs including social and psychological support to utilize the services provided by the Government of India.

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